UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

IN RE: PHARMACEUTICAL INDUSTRY AVERAGE WHOLESALE PRICE LITIGATION	MDL No. 1456 Master File No. 01-CV-12257-PBS
THIS DOCUMENT RELATES TO: ALL ACTIONS	Judge Patti B. Saris

AFFIDAVIT OF AGNES SWAYZE

I, Agnes Swayze, pursuant to 28 U.S.C. §1746, on oath, depose and state as follows:

1. My name is Agnes B. Swayze and I live in Lancaster, California. I have personal knowledge of the facts stated below.

2. I submit this Affidavit in further support of my application to be appointed as the Class Representative for Class I of the settlement with the various Track 2 defendants.

3. At the request of my counsel, John Macoretta, I again searched my records to see if I could find proof of any of the payments I made for my chemotherapy treatments. I was unable to find credit card records, bank statements or cancelled checks. I did however find several handwritten check registers which I maintained. Attached as Exhibit 1 is a copy of two pages of the check register for my Wells Fargo account. The highlighted portions indicate checks written by me to Lancaster Community Hospital for payments made for services provided to me on April 28, 2000.

4. I note that the payment for April 28, 2000 services ties directly to the item in my claim form indicating that I received sodium chloride on April 28, 2000 and incurred a co-pay obligation, see Exhibit 2.

5. I understand my counsel has contacted the banks where I maintained an account during the class period and learned that they do not have records for any checks I may have written in 2003 or earlier.

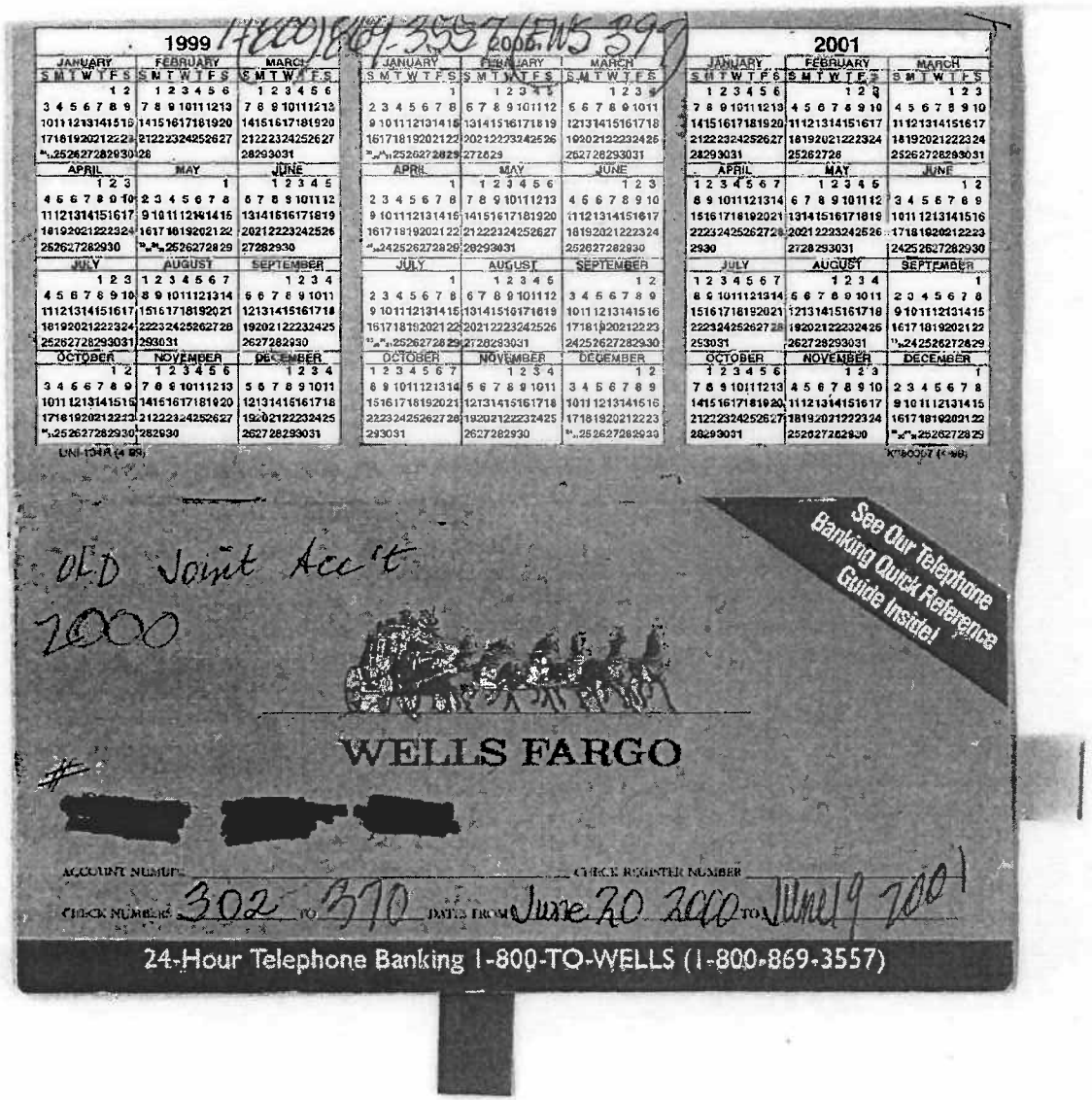
6. I want the Court to know I am again receiving treatment for my cancer, so even searching for these records was very difficult for me.

7. I joined this case as a [redacted] class representative after the Track 2 settlement had been negotiated. Nonetheless, throughout my involvement in this case I have spoken with Mr. Macoretta about the settlement, the revisions made to it over time and various objections to the settlement. Although I am not an attorney, I have some understanding of the difficulties the lawyers faced in that case and believe the settlement to be fair and reasonable for consumers.

Date: June 23, 2011

Agnes B. Swayze

EXHIBIT 1



TRANSACTION CODES: ATM–ATM Transactions, EC–Express Card Purchase, BP–Bill Payment, D–Deposit.

DATE	CHECK NO. or CODE	TRANSACTIONS CONFIRMATION NUMBER	TAX DEDUCT CODES	AMOUNT	✓	DEPOSIT AMOUNT	BALANCE
Bill Pay							
326	July 19	Lancaster Comm. Hospital April 28, 00 ER		291 00	X	7/27 Tax Deduct.	
						BALANCE	1391 08

Keep your valuables secure in a Wells Fargo Safe Deposit Box.

TRANSACTION CODES: ATM–ATM Transactions, EC–Express Card Purchase, BP–Bill Payment, D–Deposit.

DATE	CHECK NO. or CODE	TRANSACTIONS CONFIRMATION NUMBER	TAX DEDUCT CODES	AMOUNT	✓	DEPOSIT AMOUNT	BALANCE
							1391 08
		Bank fees					26 50
							1374 58
							1219 56
							1235 02
327	7/17	Lanc Comm Hosp - RADGRP 4/25/00 ER / SCAN		9 50	/	tax Deduct.	155 79

EXHIBIT 2

MUST BE POSTMARKED BY JULY 1, 2011

AWP TRACK 2 SETTLEMENT

MEDICARE PART B CLAIM FORM

IF YOU DO NOT MAKE ANY CHANGES TO THE CHART IN SECTION C, YOU DO NOT NEED TO RETURN THIS CLAIM FORM.

FOR OFFICIAL USE ONLY

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Section A: Patient Information

Please review the preprinted information below and fill in any missing information. If you need to make corrections, please make them in the space provided.

1930305

AGNES SWAYZE
1016 W NEWGROVE ST
LANCASTER CA 93534-3310

☐ If the preprinted address to the left is incorrect or out of date, **OR** if there is no preprinted data to the left, **check this box and print the patient's current name and address**

Name: _____

Address: _____

City: _____

State: ___ Zip Code: _____

(___) ___-____
Daytime Telephone Number

Please review the information printed on this claim form carefully.

- **If you make any changes: You must sign and return this claim form.**
- **If you do not make any changes: Do not return this claim form. A check will be automatically mailed to you.**

Section B: Patient Representative Information

If you are the patient, **DO NOT** complete this section. Complete this section only if you are a representative (such as a spouse, guardian, executor or personal representative) filing this claim on behalf of the patient listed above.

Representative's Name: _____ Relationship to Patient: _____

Representative's Mailing Address: _____

City: _____ State: ___ Zip Code: _____

Daytime Telephone Number: (___) ___-____

Evening Telephone Number: (___) ___-____

IF YOU DO NOT MAKE ANY CHANGES TO THE CHART IN SECTION C, YOU DO NOT NEED TO RETURN THIS CLAIM FORM.

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SD1

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IF YOU DO NOT MAKE ANY CHANGES TO THE CHART IN SECTION C, YOU DO NOT NEED TO RETURN THIS CLAIM FORM.

Section C: Instructions for Completing Medicare Part B Purchase Information

The Medicare Part B Purchase Information Chart below contains information obtained through the Centers for Medicare and Medicaid Services' records. The chart indicates that you were administered or filled a prescription for one or more of the covered drugs shown in Column A on or about the date(s) shown in Column B and paid out-of-pocket the amount shown in Column C. **If you do not make any changes to the chart in Section C, you do not need to return this claim form. A check will automatically be mailed to you.**

Medicare Part B Purchase Information Chart

	COLUMN A	COLUMN B	COLUMN C
	Name of Drug	**Date Drug Received**	**Amount Paid Out-of-Pocket**
1	SODIUM CHLORIDE	4/20/2000	$1.11
2	ADENOSINE	4/20/2000	$10.94
3	SODIUM CHLORIDE	4/28/2000	$1.31
4	SODIUM CHLORIDE	12/10/2002	$0.89
5	DEXTROSE\DEXTROSE SODIUM CHLORIDE\RINGERS LACTATED WITH DEXTROSE	12/10/2002	$1.50
6	SODIUM CHLORIDE	12/10/2002	$1.69
7	DEXAMETHASONE SODIUM\DEXAMETHASONE SODIUM PHOSPHATE	12/10/2002	$0.62
8	ALCOHOL INJECTION	12/10/2002	$1.14
9	ANZEMET (INJECTION & TABLETS)	12/30/2002	$2.11
10	EPOGEN	1/7/2003	$101.52
11	NEUPOGEN	1/7/2003	$37.18
12	NEUPOGEN	1/8/2003	$37.18
13	NEUPOGEN	1/9/2003	$37.18
14	EPOGEN	1/24/2003	$101.52
15	NEUPOGEN	1/24/2003	$37.18
16	NEUPOGEN	1/26/2003	$37.18
17	NEUPOGEN	1/28/2003	$37.18
18	EPOGEN	1/28/2003	$101.52
19	NEUPOGEN	1/29/2003	$37.18
20	EPOGEN	2/5/2003	$101.52

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PLEASE CONTINUE TO THE NEXT PAGE

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Section C: Instructions for Completing Medicare Part B Purchase Information

The Medicare Part B Purchase Information Chart below contains information obtained through the Centers for Medicare and Medicaid Services' records. The chart indicates that you were administered or filled a prescription for one or more of the covered drugs shown in Column A on or about the date(s) shown in Column B and paid out-of-pocket the amount shown in Column C. **If you do not make any changes to the chart in Section C, you do not need to return this claim form. A check will automatically be mailed to you.**

Medicare Part B Purchase Information Chart

	COLUMN A	COLUMN B	COLUMN C
	Name of Drug	**Date Drug Received**	**Amount Paid Out-of-Pocket**
21	NEUPOGEN	2/12/2003	$37.18
22	NEUPOGEN	2/13/2003	$37.18
23	NEUPOGEN	2/14/2003	$37.18
24	NEUPOGEN	2/17/2003	$37.18
25	NEUPOGEN	2/18/2003	$37.18
26	EPOGEN	2/19/2003	$101.52
27	EPOGEN	2/26/2003	$101.52
28	SODIUM CHLORIDE	3/6/2003	$0.54
29	DEXTROSE\DEXTROSE SODIUM CHLORIDE\RINGERS LACTATED WITH DEXTROSE	3/6/2003	$1.50
30	DEXAMETHASONE SODIUM\DEXAMETHASONE SODIUM PHOSPHATE	3/6/2003	$0.10
31	DEXAMETHASONE SODIUM\DEXAMETHASONE SODIUM PHOSPHATE	3/7/2003	$0.06
32	SODIUM CHLORIDE	3/7/2003	$0.31
33	ALCOHOL INJECTION	3/10/2003	$560.50
34	EPOGEN	3/12/2003	$101.52
35	EPOGEN	3/18/2003	$101.52
36	HEPARIN / HEPARIN LOCK FLUSH / HEPARIN SODIUM	11/11/2003	$0.08
37	HEPARIN / HEPARIN LOCK FLUSH / HEPARIN SODIUM	12/19/2003	$0.08
38	HEPARIN / HEPARIN LOCK FLUSH / HEPARIN SODIUM	3/18/2004	$0.07

IF YOU DO NOT MAKE ANY CHANGES TO THE CHART IN SECTION C, YOU DO NOT NEED TO RETURN THIS CLAIM FORM.

PLEASE CONTINUE TO THE NEXT PAGE

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Section C Continued

Look carefully at the list of covered drugs found on Attachment A of the Notice. Check the chart **above** to make sure it contains all of the covered drugs you were administered or filled a prescription for as a Medicare recipient from January 1, 1991 through January 1, 2005. If it does not, you may add those drugs to the chart **below**.

- Only add drugs if you were responsible for paying a percentage co-payment as a Medicare Part B recipient.
- You are not eligible for a check if a) supplemental insurance covers your entire obligation for co-payment or b) you were responsible for making only flat co-payments.
- Flat co-payments do not vary with the cost of the drug. If your supplemental insurance covered only part of your percentage co-payment obligation, you are still eligible.

In order to add drugs to the chart below:

1. Enter the name of any additional drugs in Column A;
2. Enter dates of administration in Column B;
3. Enter the amount paid in Column C; and
4. Provide one of the following acceptable proofs of a percentage co-payment for each additional covered drug:
   - (1) A receipt, cancelled check, or credit card statement that shows a payment for one of the drugs (other than a flat co-payment); or
   - (2) A letter from a doctor saying that he or she prescribed one of the drugs and you paid part of the cost of one of the drugs (other than a flat co-payment) at least once; or
   - (3) An EOB (explanation of benefits) from your insurer that shows you made or are obligated to make percentage co-payments for the covered drugs; or
   - (4) A notarized statement signed by you indicating you made or are obligated to make a percentage co-payment for the covered drugs from January 1, 1991 through January 1, 2005, including the total of all percentage co-payments for the drugs during the time period; or
   - (5) Records from your pharmacy showing that you made percentage co-payments for the covered drugs purchased from January 1, 1991 through January 1, 2005.

Additional Medicare Part B Purchase Information Chart

	COLUMN A	COLUMN B	COLUMN C
	Name of Drug	Date of Administration	Amount Paid Out-of-Pocket
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

-- ATTACH ADDITIONAL PAGES IF NEEDED --

IF YOU DO NOT MAKE ANY CHANGES TO THE CHART IN SECTION C, YOU DO NOT NEED TO RETURN THIS CLAIM FORM.

Section D: Sign and Date Your Claim Form

I declare under penalty of perjury that the information provided here is, to the best of my knowledge, correct. I also declare under penalty of perjury that I made a percentage co-payment for one or more of the drugs as indicated in this claim form at some time during the period from January 1, 1991 through January 1, 2005. If not submitting this for myself, I am authorized to submit this form on behalf of the Claimant identified above.

Signature: _____

Print Name: _____

Date: __ __ / __ __ / __ __ __ __

Section E: Mail Your Claim Form

If you did not make any changes to this document, you do not need to return this Claim Form.

Claim Forms that have been changed, along with proof of payment, must be postmarked by **July 1, 2011** and mailed to:

AWP Track 2 Settlement Administrator
P.O. Box 2417
Faribault, MN 55021-9117

If you have any questions, please call 1-877-465-8136 or visit the website at www.AWPTrack2Settlement.com.

REMINDER:

If you made changes to any information contained in Sections A, B, or C:

You must sign and return this claim form.

If you did not make any changes to the information printed on the claim form:

Do not return this claim form.
A check will be automatically mailed to you.

CERTIFICATE OF SERVICE BY LEXISNEXIS FILE & SERVE

Docket No. MDL 1456

I, Steve W. Berman, hereby certify that I am one of plaintiffs' attorneys and that, on June 24, 2011, I caused copies of **AFFIDAVIT OF AGNES SWAYZE** to be served on all counsel of record by causing same to be posted electronically via LEXIS-Nexis File & Serve.

/s/ Steve W. Berman

Steve W. Berman